Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018694	A. BUILDING: _____ B. WING _____	R-C 01/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YOU ARE HOME A	12022 125TH ST CHIPPEWA FALLS, WI 54729

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 000}	INITIAL COMMENTS On 12/12/2023, Surveyor conducted a x2 complaint investigation and verification visit at Your Are Home A. Data collection continued through 01/05/2024. Two of 2 complaints were unsubstantiated. One deficiency was identified. One deficiency was a repeat violation. See Statement of Deficiency (SOD) LCO311, dated 03/14/2023. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 4	{M 000}		
{M 458}	88.07(3)(a) PRESCRIPTION MEDICATIONS Every prescription medication shall be securely stored, shall remain in its original container as received from the pharmacy and be stored as specified by the pharmacist. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure medications were securely stored to prevent unauthorized access.	{M 458}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018694	A. BUILDING: _____ B. WING _____	R-C 01/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YOU ARE HOME A	12022 125TH ST CHIPPEWA FALLS, WI 54729

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 458}	Continued From page 1 This is a repeat deficiency. See Statement of Deficiency (SOD) LCO311, dated 03/14/2023. Findings include: The provider serves up to 4 residents within one of the following client groups: developmentally disabled; traumatic brain injury; and physically disabled. On 12/12/2023 at approximately 11:00 AM, Surveyor asked Caregiver A where the medication cabinet key was kept. Caregiver A showed Surveyor a key to a locked storage closet was hanging on the back of the storage closet door behind a hanging organizer. Caregiver A used that key to unlock the storage closet where the medication cabinet key was hanging on the wall. Caregiver A confirmed the medication cabinet key was always kept in the secured storage cabinet with the storage cabinet key left hanging on the back of the door, accessible to anyone. At 2:15 PM, Surveyor interviewed Licensee B. Surveyor discussed concerns about the storage of the medication cabinet key. Licensee B stated s/he had addressed the concerns with staff previously and would do so again. The keys to the provider's medications were accessible to anyone in the home.	{M 458}		